STANDARDS OF CARE

Los Angeles County Commission on HIV

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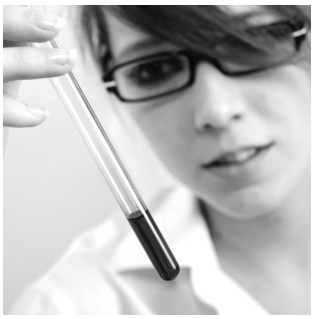


STANDARDS OF CARE

Los Angeles County Commission on HIV

MEDICAL CARE COORDINATION SERVICES

EXECUTIVE SUMMARY

SERVICE INTRODUCTION

Medical care coordination services are patient-centered activities that focus on access, utilization, retention and adherence to primary health care services, as well as on coordination and integration of services along the continuum of care for patients living with HIV. Services are conducted by qualified Registered Nurse (RN) case managers who facilitate optimal health outcomes for people living with HIV through advocacy, liaison and collaboration.

Services include:

- Intake and assessment of available resources and needs
- Nursing diagnosis
- Nursing case management plan
- Implementation and evaluation of nursing case management plan

The goals of medical care coordination include:

- Coordinating and integrating medical and psychosocial care for HIV-positive patients
- Facilitating the coordination and sequencing of primary health care services to achieve optimal health outcomes
- Helping patients locate needed health care services
- Assisting service providers in coordinating prevention and care services for patients
- Helping patients understand their medical diagnoses and treatment.
- Coaching, educating and mentoring patients and their caregivers how to self-manage their health care
- Preventing the further spread of HIV
- Educating patients on how to reduce risks for HIV infection
- Supporting patients in adhering to medical regimens and drug therapies
- Increasing self-efficacy
- Facilitating access and linkage to appropriate services in the continuum of care
- Increasing access to HIV information and education
- Identifying resources and increasing coordination between providers

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

Medical care coordination services are provided by an RN in good standing and licensed in California by the State Board of Registered Nursing. Nurses will practice with the Scope of Practice as outlined in the California Business and Professional Code, Section 2725. Medical case managers will successfully complete the Division of HIV and STD Programs (DHSP)—formerly referred to as the Office of AIDS Programs and Policy (OAPP)—HIV Case Management Certification and participate in all required recertification activities and trainings.

SERVICE CONSIDERATIONS

General Considerations: Medical care coordination will be patient-centered, respecting the inherent dignity of the patient. All medical care coordination will be client-driven, aiming to increase a patient's sense of empowerment, self-advocacy and medical self-management, as well as enhancing the overall health status of people living with HIV. All medical care coordination services will be culturally and linguistically appropriate to the target population.

Outreach: Programs providing medical care coordination services will conduct outreach to educate potential patients, HIV services providers and other supportive service organizations about the availability and benefits of medical care coordination services

Eligibility: Programs will develop and implement client eligibility requirements that give priority to clients living at or below 100% of poverty level and with the greatest health and service need.

Intake: Client intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, client intake will be completed in the first contact with the potential client

Assessment: Assessment is the systematic and continuous collection of data and information about the patient and his or her need for medical care coordination. Assessment includes a complete health history as well as supplemental information for other health and social service professionals. Assessment is completed in a cooperative, interactive, face-to-face interview process.

Nursing Diagnosis: Based on the assessment, a nursing diagnosis is developed which describes the health status of the patient (including the etiology, supporting signs, symptoms and defining characteristics of the health status problems) and the interventions that the nurse case manager recommends to address these problems and concerns.

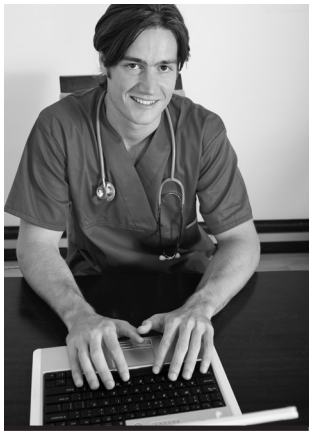
Nursing Case Management Plan: A nursing case management plan is developed as an individualized service plan. The patient will be an active participant in developing the nursing case management plan.

Implementation and Evaluation of Nursing Case Management Plan: Nursing case management plan implementation and evaluation involve ongoing contact and interventions with (or on behalf of) the patient to ensure goals are addressed that work towards improving a patient's health, restoring health maintenance or restoring health status.

Referral and Coordination of Care: Programs providing medical care coordination services will demonstrate active collaboration other agencies to provide referral to the full spectrum of HIV-related services.

Patient Retention: Programs shall strive to retain patients in medical care coordination. A broken appointment policy and procedure to ensure continuity of service and retention of patients is required.

Case Closure: Case closure is a systematic process for disenrolling patients from medical care coordination.The process includes formally notifying patients of pending case closure and completing a case closure summary to be kept on file in the patient record.



RN case managers facilitate access and linkage to services.

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all medical care coordination staff will be able to provide linguistically and culturally appropriate care to people living with HIV and complete documentation as required by their positions. Medical care coordination staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding patient confidentiality and HIPAA regulations.

Medical case managers will be RNs in good standing and licensed by the California Board of Registered Nursing. An RN providing case management services must be a graduate of an accredited nursing program with a Bachelor's (BSN) or two-year nursing associate's degree and have experience providing care to HIV-positive patients.

All medical case managers will successfully complete DHSP's Case Management Certification Training within three months of being hired and all recertifications and requisite trainings (as appropriate). In addition, medical case managers are required to attend an annual training/briefing on available public/private benefits and available benefits specialty services. Medical case managers must maintain their licenses by fulfilling the financial and continuing education requirements established by their respective professional state and national boards. Case managers must complete relevant continuing educational courses addressing HIV care-related topics.





STANDARDS OF CARE

Los Angeles County Commission on HIV

MEDICAL CARE COORDINATION SERVICES

SERVICE INTRODUCTION

Medical care coordination services are patient-centered activities that focus on access, utilization, retention and adherence to primary health care services, as well as on coordination and integration of all services along the continuum of care for patients living with HIV. Medical care coordination espouses a coordinated approach to service provision across the many systems encountered by a person living with HIV. As such, medical care coordination is considered an integrated approach to care, rather than simply a location where care is provided.

Services strive for an integrated approach to care.

Medical care coordination services will include:

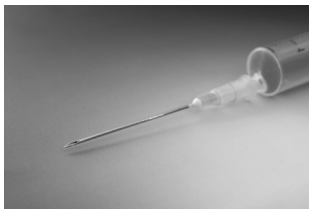
- Outreach
- Intake
- Comprehensive assessment/reassessment
- Patient acuity assessment
- Comprehensive treatment plan
- Implementation and evaluation of comprehensive treatment plan
- Referral and coordination of care
- Case conferences
- Benefits specialty services
- HIV prevention, education and counseling
- Patient retention services

All programs will use available standards of care to inform clients of their services and will provide services in accordance with legal and ethical standards. Maintaining confidentiality is critical and its importance cannot be overstated. All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

The goals of medical case coordination include:

- Coordinating and integrating medical and psychosocial care for HIV-positive patients
- Facilitating the coordination and sequencing of primary health care services to achieve optimal health outcomes
- Helping patients locate needed health care services
- Helping service providers coordinate prevention and care services for patients

- Helping patients understand their medical diagnoses and treatment
  Coaching, educating and mentoring patients and their caregivers on how to self-manage their health care
- Preventing the further spread of HIV
- Educating patients on how to reduce risks for HIV infection
- Helping patients adhere to medical regimens and drug therapies
- Increasing self-efficacy
- Facilitating access and linkage to appropriate services in the continuum of care
- Increasing access to HIV information and education
- Identifying resources and increasing coordination between providers



Recurring themes in this standard include:

- Medical care coordination will respect the dignity and self determination of patients.
- Services will be delivered to support and enhance a patient's self-sufficiency.
- All services will be based on a comprehensive assessment, around which a comprehensive treatment plan and implementation activities are developed.
- Ongoing monitoring of progress is integral to care coordination services.
- Medical care coordination staff require specialized training and ongoing patient care-related supervision.

The Los Angeles County Commission on HIV and the Division of HIV and STD Programs (DHSP)—formerly referred to as the Office of AIDS Programs and Policy (OAPP)—have developed this standard of care to set minimum quality expectations for service provision and to guarantee patients consistent care, regardless of where they receive services in the County.

This document represents a synthesis of published standards and research, including:

- *Proposed Medical Care Coordination Framework*, Los Angeles County Commission on HIV, October 8, 2007
- *Case Management, Medical Service Description*, Office of AIDS Programs and Policy
- *Psychosocial Case Management Standard of Care*, Los Angeles County Commission on HIV
- *Medical Outpatient-Specialty Services Standard of Care*, Los Angeles County Commission on HIV
- *Benefits Specialty Services Standard of Care*, Los Angeles County Commission on HIV
- *Counseling, Testing and Referral Standard of Care*, Los Angeles County Commission on HIV

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

Medical care coordination services are supervised and overseen by a team consisting of an RN and a Master's degree-level patient care manager.

RNs providing medical care coordination services will be in good standing and licensed in California by the State Board of Registered Nursing. Nurses will practice within the scope of practice as outlined in the California Business and Professional Code, Section 2725. (Please see www.rn.ca.gov for more information.)

Patient care managers providing medical care coordination services will hold a Master's degree in social work (MSW) or related degree (e.g., psychology, human services, counseling) from an accredited social work program. Patient care managers will practice

in accordance with applicable State and federal regulations, uphold the Social Work Code of Ethics (http://www.naswdc.org/pubs/code/default.asp) and comply with the staff development and education requirements noted below.

Case workers with medical specialty will hold a Licensed Vocational Nurse (LVN) license. All case workers providing medical care coordination services should successfully complete OAPP's HIV Case Worker Certification and participate in all required recertification activities and trainings.

DEFINITIONS AND DESCRIPTIONS

Assessment is a cooperative and interactive face-to-face interview process during which the patient's medical, physical, psychosocial, environmental and financial strengths, needs and resources are identified and evaluated.

Case closure is a systematic process of disenrolling patients from active medical care coordination.

Medical care coordination integrates the efforts of medical and social service providers by developing and implementing a therapeutic plan.

Medical care managers will be licensed RNs and be responsible for the patient's clinical needs and will directly track and address all medical components of the comprehensive treatment plan.

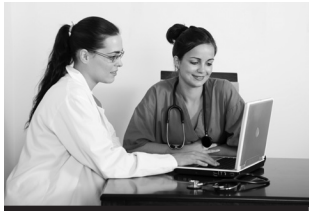
Outreach promotes the availability of and access to medical care coordination services to potential patients and service providers.

Patient care managers will hold a Master's degree in social work (MSW) or related degree (e.g., psychology, human services, counseling) and are responsible for the patient's psychosocial needs ad will track, address and or supervise these components of the comprehensive treatment plan.

Intake determines a person's eligibility for medical care coordination services.

Reassessment is a periodic assessment of a patient's needs and progress in meeting the objectives as established within the comprehensive treatment plan.

Service Provider Networks (SPNs) are the local planning networks of providers and other interested parties for service coordination and other purposes in each of the county's eight Service Planning Areas (SPAs).



Case managers serve as a catalyst for quality, cost-effective care.

HOW SERVICE RELATES TO HIV

At the end of 2013, approximately 60,050 people were estimated to be living with HIV infection in Los Angeles County. Los Angeles County comprises 40% of the total AIDS cases in the State of California (Epidemiologic Profile of HIV in Los Angeles County, 2013).

The Ryan White Program was developed to build a continuum of care for underserved

people living with HIV (Ashman, Perez-Jimenez, & Marconi, 2004). In recent years, the HIV epidemic has shifted towards even more vulnerable populations, ethnic minorities, the poor and people living with co-occurring chronic illness, substance abuse and/or mental health diagnoses. As HIV evolves into a chronic illness, treatment of these complicated subpopulations becomes even more challenging, requiring integrated and coordinated approaches to care (Stoff, Mitnick, & Kalichman, 2004). The task of integrating medical services with the necessary support services that these subpopulations require is an ongoing challenge for providers (Gardenier, Neushou, & O'Connor-Moore, 2007). The task is worthwhile—programs that have successfully integrated services using case management and care coordination services have demonstrated improved health outcomes (Goldberg, 2005; Knott, et al., 2006).

Recent changes in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 require that case coordination services further integrate medical care with psychosocial service provision (Wilson, 2006). As a result, the Commission on HIV has completed this literature search on case coordination strategies utilized in the treatment of HIV and other chronic illnesses.

The terminology used for these case coordination approaches are similar and often used interchangeably. Information below is grouped according to the specific terms found in the literature.

Case Management: The Case Management Society of America defines case management as "a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes." Case managers (or care managers) "serve as a catalyst for quality, cost-effective care by linking the patient, the physician, and other members of the care coordination team, the payer and the community" (Moro & Nash, 2003).

Though definitions for case management vary, there is general agreement that coordination of care is a primary goal. Other activities include linking clients to appropriate services to improve quality of life and to reduce the costs of expensive inpatient care, therein ensuring that more resources will be available for a larger number of people who may need them (Barney, Rosenthal & Speier, 2004).

Case management provides individual care plans for patients who are at risk for medical, social and financial challenges. Case managers provide functional assistance to patients and facilitate communication among patients and providers, but often do not have the training necessary to address complex physiological (or psychological) issues (Krumholz, et al., 2006).

A Wisconsin program (Schifalacqua, Ulich & Schmidt, 2004), led by nurse case managers, collaborated with the patient, physician, pharmacist and social worker to develop the following components:

- Comprehensive functional, social, health and resource assessment
- Interdisciplinary plans of care
- Client education and training in health, disease and self-care behaviors
- Ongoing monitoring of client's health, knowledge and progress toward goals
- Ongoing review of community and medical services throughout the continuum of care
- Ongoing reassessment and revision of care plan as needed, along with expected outcomes
- Discharge planning and transition out of case management.

This program was successful both in clinical and financial outcomes, significantly reducing intervention costs and inpatient utilization.

Case management is critical to HIV care because people living with HIV have needs that exceed mere medical care and may include emotional, financial, legal and social problems at some time during their disease process (Sonsel, 1989). The effect of case managers is felt both directly and through their role as gatekeepers to a variety of other supportive services (Messeri et al., 2002).

Case management has been demonstrated as an effective means to address the complex needs of people living with HIV (Katz, et al., 2001; Mitchell & Linsk, 2001). Even brief interventions by case managers have been associated with significantly higher rates of linkages to HIV care services (Gardner et al., 2005). Clients who have contact with case managers report less unmet need for income assistance, health insurance, home care and emotional counseling (Katz et al., 2001).

Connecting clients to resources is time-consuming and complex, often involving a mix of advocacy and mediation (Chernesky & Grube, 2000). In addition to linking clients to services, case managers assist their clients in developing personal support systems, often using themselves as the center of that support (Chernesky & Grube, 2000). A recent Canadian study demonstrated that case management services have reduced client isolation and improved health-related quality of life (Crook, et al., 2005).

Case management services are important in promoting adherence to treatment (Office of HIV Planning, 2002). Case managers help patients overcome fears about medical treatment, adhere to medication regimens and advocate for themselves with physicians (Katz, et al., 2001). Gasiorowicz and colleagues (2005) found that prevention-focused case management significantly decreased reported risk transmission behaviors, including unprotected vaginal intercourse, insertive anal intercourse and needle-sharing.

Case management is integral to medical care. Messeri and colleagues (2002) found that case managers strengthen connections to care by informing clients of the availability of appropriate medical resources, educating them about their benefits and serving as advocates in coordinating medical services and accessing insurance to cover their costs (Messeri et al., 2002). This same New York City study found formal client assessment, the development of a care plan and assistance in securing public benefits to be key factors in significantly increasing the likelihood of a client's entering and maintaining medical care (Messeri et al., 2002). The Wisconsin study demonstrated that pregnant women receiving prenatal care that included medical case management by a specialized nurse were significantly more likely to receive appropriate treatment and deliver infants with a lower rate of HIV infection than women whose care did not include services provided by nurse case managers (Havens, 1997).

Integrated Care: Integrated treatment actively combines interventions to treat presenting disorders, related problems and the needs of the whole person more effectively (Klinkenberg & Sacks, 2004). The most common components of integrated care programs include: patient education, case management, self-management support and multidisciplinary patient care (Owens, et al., 2005).

Integration of services can be achieved in any of several different ways (Klinkenberg & Sacks, 2004):

- Communicating among providers and agencies

- Cross-training staff from different disciplines
- Consulting with professionals of other disciplines
- Coordinating treatment planning (staff of different agencies meeting to discuss needs of particular clients and developing a consistent treatment plan)
- Co-locating of services (all services located at the same sight)
- Integrating treatment teams (members of different disciplines provide coordinated direct service to the same client)

A recent literature review of integrated care programs for chronically ill patients found that integrated care programs generally had positive effects on the quality of patient care (Owens, et al., 2005).

Disease Management: A shift toward a model of disease management, emphasizing coordination of care, evidence-based interventions and outcome evaluation is a relatively new phenomenon in the care of people living with chronic diseases (Krumholz et al., 2006). Key disease management strategies include an integrated approach to assessment and care planning that addresses medical, psychosocial, environmental, prevention and disease management needs while coordinating care across providers, settings and services (Fisher & Raphael, 2003). Disease management requires that practitioners identify not only physical risks, but also psychological and social risks that may affect medical, cost and quality-of-life outcomes (Claiborne & Vandenburgh, 2001). Along with physicians, nurses and social workers serve case coordination functions in the disease management model (Krumholz, et al., 2006).

Basic principles of disease management include (Krumholz, et al., 2006):

- Improvement of quality of care and outcomes
- Scientifically derived guidelines
- Focus on treatment adherence
- Clinical outcomes

All of these factors should be present in an integrated and comprehensive system of care in which the provider/patient relationship is central (Krumholz et al., 2006). Several studies have documented significant benefit from positive treatment relationships to outcomes; such relationships can contribute to a client's interest and pursuit of further treatment (Sells, Davidson, Jewell, Falzer, & Rowe, 2006).

Effective disease management requires a shift from the traditional practice of single providers treating specific episodes of illness to an interdisciplinary team coordinating all services for patients throughout the course of their illnesses (Claiborne & Vandenburgh, 2001). Providers that approach this multidisciplinary collaboration from a biopsychosocial conceptual base and prioritize services based on patients' expressed needs may experience improved engagement and retention in primary care (Soto, Bell & Pillen, 2004). Disease-specific management programs have also demonstrated significantly improved outcomes and fewer readmissions (Krumholz et al., 2006).

Social workers can provide important contributions to disease management programs because of their awareness of the psychosocial and mental health issues that affect their clients (Claiborne & Vandenburgh, 2001). Under managed care-dictated timeframes, physicians often must restrict their focus to physiological functioning and may not have time to fully explore the mental health, psychosocial and environmental needs of their patients. Social workers can help make the linkage between unmet patient needs and medical care (Claiborne & Vandenburgh, 2001).

Chronic Care: Chronic disease is managed inadequately in the United States (Dorr, et al., 2006; Berenson, 2006). Chronically ill patients are often left to initiate and coordinate their own care. Although autonomy and fragmentation of the care delivery system may thwart care management, regular communication with health care teams, including patients, nurses, physicians, social workers and others, is crucial to its success (Dorr, et al., 2006). To complicate matters, nearly one-half of patients with chronic diseases seen in outpatient care settings have multiple chronic conditions (Dorr, et al., 2006).

To positively affect quality-of-life outcomes for people living with chronic conditions, medical and supportive services must be systematically interwoven (Leutiz, Greenlick & Nonnenkamp, 2003). Chronic care models that access home- and community-based services shift from acute episode-based service delivery to an increasingly holistic approach that includes biological, psychological, social and environmental needs commonly beyond the reach of traditional medicine (Alkema, Reyes, & Wilber, 2006).

Systems accustomed to treating patients with acute illnesses struggle to provide consistent, quality care throughout the continuum of a chronic disease. Such care requires continuity of providers, attention to outcomes, observation of emerging patterns and intense support of patient self-management knowledge and skills. Global Nursing Exchange members have assembled a list of principles upon which chronic care management programs should be based (Bower, 2004).

Services promote adherence to medical regimens and drug therapies.

Among them are:

- Teaching patients and their caregivers how to manage their health is a cornerstone of effective care management programs
- Coaching, educating and mentoring clients are critical skills to have as programs shift from acute care models to chronic care management
- Understanding adherence as a complex interplay between knowledge, economics, social support, culture, values, emotional health, etc.
- Developing knowledge of community resources is key; creativity and persistence are often required to develop new resources for patients with chronic care conditions

In its report on chronic care, the California HealthCare Foundation (Berenson, 2006) notes:

> "The fully implemented Chronic Care Model encompasses multidisciplinary teams of professionals who collaboratively educate, counsel, and empower patients with self-care techniques to manage their chronic conditions (utilizing) individually tailored evidence-based treatment plans." (p. 14).

The report further emphasized the importance of patient/provider relationships. Engaging a patient's primary physician is crucial to the success of chronic care management programs. Comprehensive assessment and the careful distinguishing among patients based on their clinical conditions and specific needs were also noted as key to successful chronic disease management (Berenson, 2006).

Care Coordination: Coordinated care integrates the efforts of medical and social service providers by developing and implementing a therapeutic plan. Traditionally, coordinated care efforts have attempted to reduce inappropriate use of resources (Krumholz, et al., 2006).

Coordinated care models typically provide patients with a comprehensive assessment as they enter medical treatment and coordinate and integrate all related medical and support services (Liegel, 2006). Such coordinated care requires that interacting biological,

psychological and social needs should be addressed simultaneously, rather than separately and episodically. Behavioral interventions and support services must be coordinated with medical care to be fully responsive to clients' needs and to promote treatment adherence and health outcomes (Soto, Bell, & Pillen, 2004).

Continuity of care and care coordination are especially important as clients move across multiple service systems over time (Klinkenberg & Sacks, 2004).

Any system attempting to provide care to the complex populations of people living with HIV must develop systems that ensure continuity of care and that include:

- Consistency between primary medical care and other support services
- Seamlessness as clients move across levels and intensity of care
- Coordination of present and past treatment episodes (Klinkenberg & Sacks, 2004)

Programs instituting care coordination services have demonstrated improved clinical assessments, provider communication and care planning (Liegel, 2006). A 2006 study, which evaluated the effectiveness of systematically integrating biopsychosocial interventions with coordinated delivery of care for outpatients recovering from stroke, found that mental quality of life was significantly improved for those receiving care coordination services from social workers. It also posits that care coordination may be an important intervention for enhancing the quality of life for individuals with disabilities from causes other than stroke (Claiborne, 2006).

The interface between care coordination and flexible, comprehensive data systems used to track assessments, services and referrals was noted by several studies as key to successful coordination efforts (Liegel, 2006).

Benefits Specialty: Linking clients to resources can be a demanding a mix of advocacy and mediation (Chernesky & Grube, 2000). A 2002 New York City study found formal client assessment, the development of a care plan and assistance in securing public benefits to be key factors in a significantly increased likelihood of a client's entering and maintaining medical care (Messeri et al., 2002).

Other studies have shown that the receipt of ancillary services (including Client Advocacy) has been significantly associated increased use of primary medical care (Ashman, Conviser & Pounds, 2002). This finding may suggest that helping clients to solve problems not directly related to primary care may empower them to seek and obtain it. (Ashman, Conviser & Pounds, 2002).

Assessment: While not a specific approach to care management, all of the above-referenced approaches stressed the importance of detailed, comprehensive, biopsychosocial assessment. Because of the consistency of this finding, notes on assessment have been included here.

An accurate assessment completed by a medical or social work professional ensures that services are warranted and appropriate—"good treatment follows from good assessment." A complete assessment also ensures efficiency of service provision, allowing the service intensity (or amount) to vary based upon individualized need. Accurate assessment also ensures that needs can be realistically met and determines the provider skill level necessary for each service. Assessment can also successfully screen for emotional distress and mental health problems.

Social work assessment must be flexible enough to identify all the problems that a client may be encountering, not only those that have been validated by standardized research

protocols. An accurate assessment of chronically ill patients is challenging because of the many domains of interest and the frequently changing circumstances of a given client (Vourlekis, Ell & Padgett, 2005).

SERVICE COMPONENTS

Medical care coordination services are patient-centered activities which focus on access, utilization, retention and adherence to primary health care services, as well as coordinating and integrating all services along the continuum of care for patients living with HIV. Medical care coordination services will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by care coordination staff and other professionals to whom they are referred. Such patient-practitioner discussions are relationship-building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen. Medical care coordination staff are directed to patient-oriented HIV/AIDS care and prevention websites such as Project Inform (www.projectinform.org) and The Body (www.thebody.com) for more information about discussing HIV/AIDS from a patient-centered approach.

All medical care coordination services will be patient-driven, aiming to increase a patient's sense of empowerment, self-advocacy and medical self-management, as well as enhancing the overall health status of people living with HIV. All medical care coordination services will be culturally and linguistically appropriate to the target population. (See Program Requirements and Guidelines in the Standards of Care Introduction.)

The overall emphasis of ongoing medical care coordination services should be on facilitating the coordination, sequencing and integration of primary health care and all other services in the continuum of care to achieve optimal health outcomes.

Medical care coordination services in Los Angeles County will include (at minimum):

- Outreach
- Intake
- Comprehensive assessment/reassessment
- Patient acuity assessment
- Comprehensive treatment plan
- Implementation and evaluation of comprehensive treatment plan
- Referral, coordination of care and linkages
- Case conferences
- Benefits specialty services
- HIV prevention, education and counseling
- Patient retention services

GENERAL SERVICE CONSIDERATIONS

All patients receiving Ryan White-funded services will also be enrolled in medical care coordination services. All medical outpatient facilities providing Ryan White-funded care must have a medical care coordination program, either as part of, or attached to, their services. Each medical care coordination program will be a single, unified program, even if it involves multiple providers.

Physical co-location of the medical outpatient clinics and medical care coordination programs may not always be necessary, and will be determined based on the needs of the program, the patient population and the providers delivering the service. Whether co-located or located on its own premises, medical care coordination programs must operate from a central location which serves as an administrative hub and primary program venue. As such, medical care coordination is considered an integrated approach to care, rather than simply a location where care is provided.

Medical care coordination programs must be co-managed by both a medical care manager (RN license) and patient care manager (holding a Master's degree in social work or related field (psychology, human services, counseling). The care management team will be responsible for assigning patients to care workers (based on patient need) and for supervising and monitoring all aspects of patient-related care. Depending on the size of the program and volume of patients, the program may employ additional case workers who are directly supervised by one or both of the care managers. In the case of a smaller program, the medical and patient care managers both work directly with all patients on an ongoing basis. Caseloads should range from a minimum of 30 (when all patients present with the highest acuity needs) to a maximum of 300 (when all patients present with low acuity and require only periodic contact) for each care manager and/or case worker.

The medical care manager is responsible for the patient's clinical needs and is expected to directly track and address all medical components of the comprehensive treatment plan both within the Ryan White system of care and outside of it. The patient care manager is responsible for the patient's psychosocial needs and will track, address and/or supervise these components of the comprehensive treatment plan.

To ensure appropriate care coordination services, each program will maintain at least a half-time equivalent medical care manager and a half-time equivalent patient care manager. All programs will be required to be open at least 40 hours per week (with normal business hours to be determined, based in part on patient population needs). In addition, programs must develop contingencies for 24-hour on-call services.

Because of the central role that public and private benefits play in the care of people living with HIV, programs providing medical care coordination services will ensure that benefits specialty services are made available for all patients. Indeed, a significant portion of a caseworker's time may be spent in assisting patients to apply for benefits both inside and outside the Ryan White-funded system. Benefits specialty services provide intensive attention and follow-up to help patients access benefits outside the Ryan White-funded system of care. Care coordination programs will provide these services directly with their own staff or will contract these services through another agency or program that specializes in benefits services.

Care coordination programs may choose to engage additional providers for specific services (e.g., mental health, substance abuse) or will be expected to establish comprehensive service agreements with such providers that will facilitate the program's access to those additional services.

Patients may enter the continuum of care from any Ryan White-funded service and will be linked to medical care coordination services at that time.

Following are descriptions of specific program components required of medical care coordination programs. These components may be provided in any sequence; their ordering below should not necessarily dictate the progression of services.

OUTREACH

Programs providing medical care coordination services will develop and implement an outreach plan that guides the program's efforts to engage:

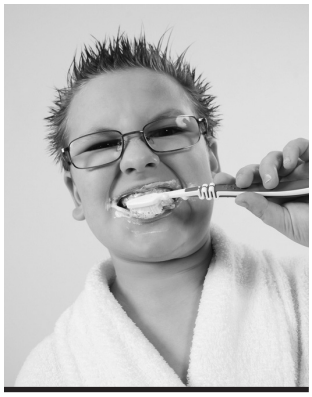
- Self-managed patients
- Patients who have fallen out of care
- Patients who are aware of their HIV status, but not in care ("unmet need")

Please refer to the "Patient Retention" section of this standard for guidance in communication and follow-up with patients.

In addition to these activities targeted to individuals, programs will also conduct outreach activities to educate HIV services providers and other supportive service organizations about the availability and benefits of medical care coordination services for people living with HIV within Los Angeles County. Programs will work in collaboration with HIV primary health care and support services providers, as well as HIV testing sites.

SPNs are expected to help facilitate outreach activities on behalf of medical care coordination programs in each of the County's Service Planning Areas SPAs.

STANDARD	MEASURE
Medical care coordination programs will outreach to potential providers and patients who: • Are self-managed • Have fallen out of care • Are aware of their status, but not yet in care	Outreach plan on file at provider agency. Programs will monitor current outreach/return to care rates and demonstrate efforts to improve them. Program monitoring to confirm activities.



Patients are active partners in their self-care regimen.

INTAKE

Patient intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, patient intake will be completed in the first contact with the potential patient. Programs will assess individuals in crisis to determine what other interventions are appropriate, either within the agency, or by immediate referral.

The complete intake process, including registration and eligibility, is required for every patient at his or her point of entry into the service system. If an agency or other funded entity has the required information and documentation on file in the agency record for that patient or in the countywide data management system, further intake is not required.

In the intake process and throughout medical care coordination, patient confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the most current Release of Information (specification should indicate the type of information that can be released).

As part of the intake process, the client file will include the following information (at minimum):

- Written documentation of HIV status
- Proof of Los Angeles County residency

- Verification of financial eligibility for services
- Date of intake
- Client name, home address, mailing address and telephone number
- Emergency and/or next of kin contact name, home address and telephone number

Required Forms: Programs must develop the following forms in accordance with state and local guidelines. Completed forms are required for each patient:

- Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).
- Limits of Confidentiality (confidentiality policy)
- Consent to Receive Services
- Patient Rights and Responsibilities
- Patient Grievance Procedures
- Notice of Privacy Practices (HIPAA)

STANDARD	MEASURE
Intake process will begin during first contact with patient (unless already on file in agency).	Intake tool is completed and in patient file to include (at minimum): • Documentation of HIV status • Proof of LA County residence • Verification of financial eligibility • Date of intake • Patient name, home address, mailing address and telephone number • Emergency and/or next of kin contract name, home address and telephone number
Confidentiality policy and Release of Information will be discussed and completed.	Release of Information signed and dated by patient on file and updated annually.
Consent for Services will be completed.	Signed and dated Consent in patient record.
Patient will be informed of Rights and Responsibility and Grievance Procedures.	Signed and dated forms in patient record.
Patient will be informed of privacy rights (HIPAA).	Signed and dated form in patient record.

PATIENT ASSESSMENT/REASSESSMENT

Assessment is the systematic and continuous collection of data and information about the patient and his or her need for medical care coordination services. Assessment identifies and evaluates a patient's medical, physical, psychosocial, environmental and financial strengths, needs and resources. The patient assessment, reassessments and comprehensive treatment plans must be performed by the medical care manager and patient care manager team, or by staff with equivalent licensure and education (RN/MSW or related).The medical information and medical assessment portions of the assessment and reassessment must be completed by the medical care manager (or RN).

Comprehensive assessment is conducted to determine the:

- Patient's needs for treatment and support services
- Medical treatment plan (if one exists)
- Patient's current capacity to meet those needs
- Ability of the patient's social support network to help meet patient need
- Extent to which other agencies are involved in patient's care
- Areas in which the patient requires assistance in securing services

Assessment includes a complete health history as well as other pertinent information for

other health and social service professionals. The assessment organizes and synthesizes patient information from many sources.

Assessment is completed in a cooperative, interactive, face-to-face interview process. The assessment must be completed as soon as possible and will document the patient's needs, along with mutual decisions made regarding needs and services. While every effort will be made to complete the assessment within 30 days, referrals to needed services can begin before the assessment has been completed. If an assessment cannot be completed in 30 days, the reasons for non-completion will be documented in the patient record. Comprehensive assessments and reassessments will be continually updated and completed when there are significant changes in a patient's status, when the patient has left and reentered medical care coordination services, or (at minimum) once per year. Information gathered in the comprehensive assessment or reassessment will be used to develop or update the patient's comprehensive treatment plan (CTP).

Comprehensive assessment/reassessments will include (at minimum):

- Date of assessment or reassessment
- Signature and title of staff person completing the assessment ore reassessment
- Comprehensive medical information, including:
  - Patient's medical status, including a health systems review to gather history of HIV disease and other related illnesses, relevant medical and psychosocial information
  - Medical treatment plan (if one exists)
  - Description of current physiological and psychosocial status
  - Current medical care, including names of medical providers, eligibility and participation in other HIV-related services
  - Medical diagnoses and likely complications
  - Tests, treatment regimens and possible pharmacological complications
  - Medication review, profile assessment and pharmacy needs
  - Assessment of success and problems with adhering to medication regimens and medical appointments
  - Patient's and his or her social affiliates' risks for HIV transmission, need for health education, risk reduction education and support
  - Assessment of the provider's level of expertise related to the needs of the patient
- Patient's level of understanding and educational needs related to diagnosis, treatment options, prognosis, financial resources
- Assessment of psychological adjustment and coping mechanisms
- Consultation with patient's health care and social service providers to gather additional data necessary for assessment
- Reassessment of prior problems to assess current status of prior issues (in the case of reassessment)
- Patient strengths, needs and available resources in the following areas:
  - Mental health
  - Substance use, history and treatment
  - Nutrition/food
  - Medication adherence and accessibility
  - Life management skills/activities of daily living (ADL)
  - Housing and living situation
  - Family and dependent care issues
  - Transportation
  - Language/literacy skills
  - Cultural factors
  - Religious/spiritual support
  - Social support system

- Relationship history
- Domestic violence
- Abuse history and risk assessment
- Financial resources
- Employment
- Education
- Legal issues
- Incarceration history
- Comprehensive assessment of risk behaviors
- Comprehensive assessment of HIV prevention issues
- Environmental factors

- Benefits assessment which determines a patient's need for public benefits and entitlements; educates a patient about available benefits and entitlements; identifies appropriate benefits and entitlements with the patient; preliminarily assesses a patient's eligibility for benefits and entitlements; and provides necessary forms and instructions, as indicated. Benefits assessments may include:
  - Completed Benefits Assessment/Information form
  - Notation of functional barriers
  - Brief notation of relevant benefits and entitlements and record of forms provided
- Identified resources and referrals to assist patient in areas and need
- Patient's acuity level and date of acuity assessment

In addition, when indicated, a patient's primary support person should be assessed for his or her HIV knowledge base, health status, expectation and ability to serve as patient's primary caretaker and support the patient in prevention and risk reduction behaviors.

Emergencies or medical and/or psychosocial crisis may require quick coordination decisions to mitigate the acute presenting issues before completing the entire intake/assessment. A brief, initial abbreviated assessment provides an opportunity to determine if the patient is in crisis and to begin the intervention process before formal assessment is completed.

STANDARD	MEASURE
Assessments will be completed within 30 days following intake. Updates to the assessment will be done continually, but no less than once every year.	Assessment or update on file in patient record: • Date • Signature and title of staff person • Comprehensive medical information (as detailed in this document) • Patient's educational needs related to treatment • Assessment of psychological adjustment and coping • Consultation with health care and social service providers • Reassessment of prior problems to assess current status of prior issues (in the case of reassessment) • Patient's strengths, needs and resources (as detailed in this document) • Benefits assessment A patient's primary support person should also be assessed for his or her ability to serve as patient's primary caretaker (when indicated).
Assessment, reassessments and comprehensive treatment plans must be performed by the medical care manager and patient care manager team, or equivalents. Medical assessment must be completed by the medical care manager (or RN).	Program review and monitoring to confirm.

PATIENT ACUITY ASSESSMENT

Patient acuity levels will be assessed using the components of the intake and comprehensive assessment and based upon a patient's level of functioning and/or current need. Acuity measurements include aspects of both the medical and psychosocial arenas. Acuity assessments will be completed by the medical/patient care management team using a countywide standardized acuity assessment tool that equally includes both medical and psychosocial concerns.

Based on all information gathered, patients will be sorted into the following categories:

- Self-managed: For patients presenting no need or desire for direct care coordination services;
- Low acuity: For patients presenting some need, but whose needs are relatively easily addressed;
- Medium acuity: For patients presenting more complicated needs requiring a greater level of intervention to mitigate;
- High acuity: For patients presenting the most complex and challenging needs; and
- Crisis acuity: For patients presenting in crisis who require immediate, high frequency and/or prolonged contact.

If, in the course of intake and comprehensive assessment, it is determined that a patient's medical and/or psychosocial needs prevent him or her from participating actively in medical care coordination services, he or she will be linked to home-based case management services, skilled nursing or hospice care.

Acuity levels will be updated on an ongoing basis, dependent upon patient need, but not less than once per year. Acuity level assessment/reassessment is an ongoing component in the course of the standard contact/visit.

After careful review of all intake, assessment and acuity materials, the RN and social work care management team will assign a primary contact to each patient that best matches the patient's presenting problem and/or primary concern to the worker's expertise.

STANDARD	MEASURE
Acuity levels will be assigned for all patients by care management team utilizing standardized, countywide acuity assessment tool.	Completed acuity tool on file in patient record. Patients will be assigned to one of the following categories: • Self-managed • Low acuity • Medium acuity • High acuity • Crisis acuity
Patients unable to actively participate in medical care coordination services will be referred to home-based case management, skilled nursing or hospice care.	Documentation of linked referral on file in patient record.
Patient acuity will be updated on an ongoing basis, dependent upon patient need, but not less than once per year.	Program monitoring and chart review to confirm.
RN and social work care management team will assign a primary contact to each patient.	Program monitoring and chart review to confirm.

COMPREHENSIVE TREATMENT PLAN (CTP)

A comprehensive treatment plan is an individualized multidisciplinary service plan to be

completed within 30 days of finalizing the comprehensive assessment. The comprehensive treatment plan is based on the following (at minimum):

- Medical diagnosis
- Nursing diagnosis
- Age
- Medical history
- Mental health history and current diagnosis
- Substance abuse history and current diagnosis
- Support systems
- Geographic location
- Sources of funding and financial support
- Community HIV resources
- Legislative requirements
- Assessment of strengths, needs and resources

For those patients with benefits needs, the CTP will include a benefits plan developed with the patient to determine the benefits and entitlements for which the patient will apply. Care coordination staff or benefits specialists acting as advocates are responsible for providing advice, referrals and other assistance necessary to carry out the benefits portion of the CTP. Through office visits, home visits and/or phone calls, the advocate will work with the patient to obtain the services or information necessary to complete the benefit/entitlement process. Patients with insignificant or no apparent functional barriers will be provided with necessary forms and instructions. Staff will follow up within two weeks to check patient's progress in completing and applying for benefits and entitlements. Patients with significant functional barriers will be assisted in completing and applying for benefits and entitlements at that time.

The patient will be an active participant in developing the comprehensive treatment plan. All interested parties should agree to the plan before beginning implementation.

Comprehensive treatment plans will include:

- Name of patient and care manager/case worker
- Date and signature of care manager/case worker and care management team
- Date and signature of the patient on the initial and subsequent CTPs
- Description of flexible short- and long-term patient goals, desired outcomes and dates of goal establishment
- Steps to be taken by patient, care manager/case worker and others to accomplish goals
- Timeframe by which goals are expected to be met
- Number and type of patient contacts based on acuity level (at minimum):
  - Self-managed: Annual contact (face-to-face or by telephone) for updates and reassessment of needs
  - Low acuity: Quarterly contact (face-to-face or by telephone)
  - Medium acuity; Monthly contact (face-to-face or by telephone)
  - High acuity: Monthly face-to-face contact
  - Crisis acuity: At least weekly contact, preferably face-to-face
- Concrete recommendations on how to implement comprehensive treatment plan
- Contingencies for anticipated problems or complications
- Disposition of each goal as it is met, changed or determined to be unattainable
- Notation of benefits and entitlements to which the patient will apply
- Notation of functional barriers status and requisite next steps
- Disposition of the application for each benefit or entitlement as it is completed, changed or determined to be unattainable

In rare cases, due to the type of treatment, immediacy of services and/or their confidential nature (e.g., mental health, legal services), the CTP may be limited to referencing, rather than detailing, a specific treatment plan and/or the patient's agreement to seek and access those specific services.

STANDARD	MEASURE
Multidisciplinary CTPs will be developed in conjunction with the patient within 30 days of completing the comprehensive assessment.	CTP on file in patient record includes (at minimum): • Name of patient and care manager/case worker • Date/signature of case worker and care management team • Date/signature of the patient • Patient goals, outcomes and dates of goal establishment • Steps to be taken to accomplish goals • Timeframe for goals • Number and type of patient contacts • Recommendations on how to implement plan • Contingencies for anticipated problems or complications • Disposition of goals • Benefits plan (as indicated)

IMPLEMENTATION AND EVALUATION OF CTP

CTP implementation and evaluation involve ongoing contact and interventions with (or on behalf of) the patient to ensure goals are addressed that work towards improving a patient's health and resolving psychosocial needs.

In the implementation and evaluation phase, medical care coordination staff are responsible for (at minimum):

- Providing linked referrals, patient advocacy and appropriate interventions based on the intake, assessment and CTP
- Monitoring changes in the patient's condition or circumstances, updating/revising the CTP and providing appropriate interventions and linked referrals.
- Monitoring lab values and adherence
- Ensuring that care is coordinated among the patient, caregivers and service providers
- Conducting ongoing monitoring and follow-up with patients and providers to confirm completion of referrals, service acquisition, maintenance of services and adherence to services
- Advocating on behalf of patients with other service providers
- Empowering patients to develop and utilize independent living skills and strategies
- Assisting patients in resolving any barriers to completing referrals and accessing or adhering to services
- Actively following up on established goals in the CTP plan to evaluate patient progress and determine appropriateness of services
- Maintaining ongoing patient contact as outlined in CTP
- Actively following up within the next business day after discharge from the hospital when the medical team is aware of hospitalization. (If follow-up activities are not appropriate or cannot be conducted within the prescribed time period, care coordination staff will document reason(s) for the delay.)
- Actively following up within one business day with patients who have missed a medical care coordination appointment. (If follow-up activities are not appropriate or cannot be conducted within the prescribed time period, care coordination staff will document reason(s) for the delay.)
- Collaborating with the patient's other service providers for coordination and follow-up

Current dated and signed progress notes, detailing activities related to implementing and evaluating, will be kept on file in the patient record. The following documentation is required (at minimum):

- Description of all patient contacts, attempted contacts and actions taken on behalf of the patient
- Date and type of contact
- Description of what occurred during the contact
- Changes in the patient's condition or circumstances
- Progress made towards achieving goals identified in the CTP
- Barriers identified in goal process and actions taken to resolve them
- Linked referrals and interventions provided
- Current status and results of linked referrals and interventions
- Barriers identified in completing linked referrals and actions taken to resolve them
- Time spent with, or on behalf of, the patient
- Care coordination staff's signature and professional title

STANDARD	MEASURE
Care coordination staff will: • Provide referrals, advocacy and interventions based on the intake, assessment and comprehensive treatment plan • Monitor changes in the patient's condition • Monitor lab values/adherence • Update/revise the CTP • Provide interventions and linked referrals • Ensure coordination of care • Conduct monitoring and follow-up • Advocate on behalf of patients • Empower patients to utilize independent living strategies • Help patients resolve barriers • Follow up on plan goals • Maintain ongoing contact based on need • Follow up after discharge from the hospital • Follow up missed appointments by the end of the next business day • Collaborate with the patient's other service providers for coordination and follow-up	Signed, dated progress notes on file that detail (at minimum): • Description of patient contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the patient's condition or circumstances • Progress toward plan goals • Barriers to plan and actions taken to resolve them • Linked referrals and interventions and current status/results of same • Barriers to referrals and interventions/actions taken • Time spent • Care coordination staff's signature and title

PATIENT SELF-EFFICACY AND CARE

Medical care coordination programs will teach patients and their caregivers effective HIV disease self-efficacy skills to improve self-sufficiency health outcomes. Staff will coach, educate and mentor clients on the skills necessary to interact effectively with all levels of service providers and to become increasingly informed and independent consumers. As appropriate, staff will encourage patients to actively participate in facilitating the multi-disciplinary communication between all of their providers to ensure continuity of treatment objectives and care.

STANDARD	MEASURE
Medical care coordination staff will teach patients and their caregivers effective HIV disease self-efficacy skills.	Documentation of self-efficacy education on file in patient record.

REFERRAL AND COORDINATION OF CARE

Programs providing medical care coordination services will actively collaborate with other agencies to provide referral to the full spectrum of HIV-related services.

Because resource referral and coordination is such a vital component of medical care coordination services, programs must maintain a comprehensive list of target providers (both internal and external), including, but not limited to, the HIV LA Resource Directory, for the full spectrum of HIV-related and other services. Program staff will maintain knowledge of local, state and federal services available for people living with HIV.

Programs providing medical care coordination services will be required to establish linkages with Ryan White-funded and other non-Ryan White-funded services to strengthen their programmatic responsiveness (e.g., mental health, substance abuse referrals). Programs will participate in network agreements within the program's service area (e.g., supportive services agencies). Programs will also participate in system agreements with other funded medical care coordination programs which will detail the steps necessary to facilitate transfer of patients between programs, when indicated. These system agreements will also accommodate the needs of patients who access other Ryan White-funded services beyond the capacity of a specific medical care coordination program.

Patients will be taught HIV self-efficacy skills.

Programs will develop written procedures and protocols for referring patients to other providers, networks and/or systems. Referral systems must include a process for tracking and monitoring referrals and their results; special attention will be given to those referrals for which the patient did not follow through.

When a patient receives services from providers in differing care coordination programs, the patient's medical case worker/care manager will be considered the primary contact and responsible for coordination activities.

Patients who receive care outside of the Ryan White-funded system are still eligible for medical care coordination services. While working with non-contracted providers may prove challenging, the case worker/care manager must make every effort to engage these "private" providers and help to coordinate all aspects of a patient's care. Such efforts to contact and include providers will be documented in the patient record. If difficulties are encountered in coordinating care with other providers, the care management team and/or program administration will be notified for additional follow-up and/or possible resolution.

STANDARD	MEASURE
Medical care coordination programs will maintain a comprehensive list of providers for full spectrum HIV-related and other service referrals.	Referral list on file at provider agency.
Care coordination programs will collaborate with other agencies, providers, networks and systems to provide effective, appropriate referrals.	Memoranda of Understanding detailing collaborations on file at provider agency.
Medical care coordination programs will develop procedures and protocols for referrals.	Written procedures and protocols on file at provider agency that includes process for tracking and monitoring referrals.
Case workers/care managers in medical care coordination programs will actively coordinate all care-related services for their patients.	Record of care coordination activities on file in patient record.
Difficulties coordinating care with other providers will be reported to the care management team or program administration for further follow-up.	Notation of report to care management/administration on file in patient record.

CASE CONFERENCES

Multidisciplinary case conferences are a critical component of medical care coordination services. Case conferences convene a patient's physician and other care providers to assess progress in meeting the needs identified in the patient's CTP and to strategize further responses.

Case conferencing is an opportunity to address major life transitions for the patient and should be conducted when possible under those circumstances. Due to logistical complications, there are no required frequencies for convening case conferences. Rather, programs are expected to convene case conferences based on patient need and acuity level.

Documentation of case conferences shall be maintained within each patient record and include:

- Date of case conference
- Names and titles of participants
- Medical and psychosocial issues and concerns identified
- Description of guidance and/or follow-up plan
- Results of implementing guidance/follow-up

STANDARD	MEASURE
Programs will convene case conferences that include the patient's physician and other care providers when feasible and appropriate.	Documentation on file in patient record to include: • Date of case conference • Names and titles of participants • Issues and concerns identified • Guidance and/or follow-up plan • Results of implementing guidance/follow up

APPEALS COUNSELING AND FACILITATION

Patients who have been denied a benefit or entitlement will be offered individual appeals counseling and facilitation services. Care coordination staff/specialists will educate and advise patients on methods to address appeals and, when indicated, accompany them to the appeal in a facilitative role (not as a legal representative).

If a staff/specialist deems that further legal assistance is required to successfully negotiate an appeal, patients will be referred to Ryan White-funded or other legal service providers.

Documentation for appeals counseling and facilitation services will be kept in the form of a progress note in the patient chart and should include (at minimum):

- Date
- Brief description of counseling provided
- Time spent with, or on behalf of, the patient
- Legal referrals (as indicated)
- Staff/specialist's signature and title

If a patient does not attend a scheduled appeals counseling appointment, staff/specialists will attempt to follow up within one business day.

STANDARD	MEASURE
As necessary, staff/specialists will assist patients with appeals counseling and facilitation. Cases that require further legal assistance will be referred to Ryan White-funded or other legal service provider.	Signed, dated progress notes on file in patient record that detail (at minimum): • Brief description of counseling provided • Time spent with, or on behalf of, the patient • Legal referrals (as indicated)
Staff/specialists will attempt to follow up missed appointments within one business day.	Progress note on file in patient chart detailing follow-up attempt.

HIV PREVENTION, EDUCATION AND COUNSELING

Medical care coordination staff will provide health information and education to patients, regarding HIV prevention, transmission and risk behavior management. Prevention, education and counseling services will also be offered to family, partners and social affiliates.

Medical care coordination staff will:

- Screen patients for risk behaviors
- Communicate prevention messages to patients
- Discuss sexual practices and drug use with patients
- Positively reinforce changes to safer behavior
- Refer patients for substance abuse treatment
- Facilitate partner notification, counseling and testing
- Educate patients about other sexually transmitted and communicable diseases

Education and counseling will be provided within the guidelines and recommendations described in "Incorporating HIV prevention into the medical care of persons living with HIV," *Morbidity and Mortality Weekly Report Recommendations Report*, July 18, 2003/Vol.52/ No.RR-12). Striving for seamless service delivery, incorporating specialized prevention staff or linking patients to specialized prevention programs Comprehensive Risk Counseling and Services (CRCS) may be necessary in some cases.

STANDARD	MEASURE
Medical care coordination staff will provide prevention and risk management education and counseling to all patients. Partners and social affiliates will be offered these services as appropriate.	Record of services on file in patient record.
Medical care coordination staff will: • Screen for risk behaviors • Communicate prevention messages • Discuss sexual practices and drug use • Reinforce safer behavior • Refer for substance abuse treatment • Facilitate partner notification, counseling and testing • Identify and treat sexually transmitted diseases	Record of prevention services on file in patient medical record.
When indicated, patients will be referred to appropriately credentialed/licensed professionals for prevention education and counseling.	Record of linked referral on file in patient record.

PATIENT RETENTION

Programs will strive to retain patients in medical care coordination services. To ensure continuity of service and retention of patients, programs will be required to establish a

broken appointment policy. Follow-up can include telephone calls, written correspondence and/or direct contact. Programs will demonstrate due diligence through multiple efforts to contact patients by phone or by mail. Such efforts shall be documented in the progress notes within the patient record.

In addition, programs will develop and implement a contact policy and procedure to ensure that patients who are homeless or report no contact information are not lost to follow-up.

STANDARD	MEASURE
Programs will develop a broken appointment policy to ensure continuity of service and retention of patients.	Written policy on file at provider agency.
Programs will provide regular follow-up procedures to encourage and help maintain a patient in medical care coordination services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
Programs will develop and implement patient contact policy for homeless patients and those with no contact information to ensure they are not lost to follow-up.	Contact policy on file at provider agency. Program review and monitoring to confirm.

CASE CLOSURE

Case closure is a systematic process for disenrolling patients from medical care coordination services. The process includes formally notifying patients of pending case closure and completing a case closure summary to be kept on file in the patient record. All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for case closure.

Cases may be closed when the client:

- Relocates out of the service area
- Has had no direct program contact in the past six months
- Is ineligible for the service
- No longer needs the service
- Discontinues the service
- Is incarcerated long term
- Uses the service improperly or has not complied with the client services agreement
- Has died

When appropriate, case closure summaries will include a plan for patient's continued success and ongoing resources to be utilized. At minimum, case closure summaries will include:

- Date and signature of both the medical and patient care managers
- Date of case closure
- Status of the comprehensive treatment plan
- Status of primary health care and support service utilization
- Referrals provided
- Reasons for disenrollment and criteria for reentry into services

STANDARD	MEASURE
Patients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in patient record.

STANDARD	MEASURE
Medical care coordination cases may be closed when the client: • Relocates out of the service area • Has had no direct program contact in the past six months • Is ineligible for the service • No longer needs the service • Discontinues the service • Is incarcerated long term • Uses the service improperly or has not complied with the client services agreement • Has died	Case closure summary on file in patient chart to include: • Date and signature of care coordination staff • Date of case closure • CTP status • Status of primary health care and service utilization • Referrals provided • Reason for closure • Criteria for reentry into services

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all care medical care coordination staff will be able to provide linguistically and culturally appropriate care to people living with HIV and complete documentation as required by their positions. Medical care coordination staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding patient confidentiality and HIPAA regulations.

To ensure appropriate care coordination services, each program will maintain at least a half-time equivalent medical care manager and a half-time equivalent patient care manager.

Care Managers – Medical: Medical care managers will be RNs in good standing and licensed by the California Board of Registered Nursing. An RN providing care coordination services must be a graduate of an accredited nursing program with a bachelor's (BSN) or two-year nursing associate's degree. The RN must practice within the scope of practice defined in the California Business & Professional Code, Section 2725 RN Scope of Practice (www.rn.ca.gov).

Medical care managers will practice in accordance with applicable State and federal regulations. Care managers will uphold the Code of Ethics for Nurses with Interpretive Statements (2001: ANA Board of Directors and Congress of Nursing Practice and Economics). Additionally, medical care managers will comply with special codes of ethics or HIV/AIDS policies from their national professional associations (see www.nursingworld.org for ANA Position Statements and www.anacnet.org for Policy Position Statements and Resolutions.)

Care Managers – Social Work: Patient care managers providing medical care coordination services will hold a Master's degree in social work (MSW) or related Master's degree (e.g., psychology, human services, counseling) from an accredited program. Patient care managers' case workers will practice in accordance with applicable State and federal regulations, uphold the Social Work Code of Ethics (http://www.naswdc.org/pubs/code/default.asp) and comply with the staff development and education requirements noted below.

Case Workers: Case workers will hold one of the following (at minimum):

- A Bachelor's degree in an area of human services
- A high school diploma (or GED equivalent) and at least one year's experience providing direct patient care in a related health services field

Case workers with medical specialty will be an LVN or certified medical assistant with at least one year's experience working in HIV care or an LVN license and have at least three years' experience providing direct patient care within a related health services field.

Further, all case workers will have:

- Knowledge of HIV/AIDS and related issues;
- Effective interviewing and assessment skills;
- Ability to appropriately interact and collaborate with others;
- Effective written/verbal communication skills;
- Ability to work independently;
- Effective problem-solving skills;
- Ability to respond appropriately in crisis situations; and
- Effective organizational skills.

All medical care coordination care managers and case workers will successfully complete an DHSP-approved case worker training within three months of being hired and all requisite trainings (as appropriate). In addition, medical care coordination care managers and case workers are required to attend an annual training/briefing on available public/private benefits and available benefits specialty services. RNs are encouraged to pursue registration as an AIDS certified RN offered by the Association of Nurses in AIDS Care and the HIV/AIDS Nursing Certification Board (see www.anacnet.org).

All care managers and case workers providing benefits specialty services will successfully complete a countywide benefits specialty training within three months of being hired. In addition, care managers and case workers providing benefits specialty services will successfully complete certification in CARE/Health Insurance Premium Payment Program (CARE/HIPP) and AIDS Drug Assistance Program (ADAP) within six months of being hired, as well as any requisite trainings (as appropriate).

An exemption process shall be developed by DHSP that allows programs to consider candidates whose qualifications do not meet all the above-referenced requirements, but whose particular skills and experiences might make him/her an appropriate staff member. Such exemptions will be cleared through DHSP before hiring is initiated.

Staff Development and Education: Medical care coordination staff must maintain their licenses by fulfilling the financial and continuing education requirements established by their respective professional state and national boards. Care managers and case workers must complete a minimum of eight hours of continuing education in HIV care-related topics per year.

In selecting other continuing education courses to fulfill licensing requirements, care managers are encouraged to select a majority of courses related to their respective scopes of practice and courses related to services within the HIV/AIDS continuum's primary health care core.

Patient Care-Related Supervision: Supervision is required of all medical case workers to provide guidance and support. Patient care-related supervision will be provided for all case workers at a minimum of four hours per month. Such patient care-related supervision may be conducted in individual or group/multidisciplinary team case conference formats. Supervision will be provided by the RN care manager and social work care manager who co-direct the program.

Patient care-related supervision will address patients' medical and psychosocial issues and

concerns, provide general clinical guidance and help to develop follow-up plans for case workers. Supervision will assist in problem-solving related to patients' progress towards goals detailed in the comprehensive treatment plan and to ensure that high-quality medical care coordination services are being provided.

Programs will ensure that each active patient is discussed as is feasible and appropriate. For each patient discussed, the supervisor will address the identified medical and psychosocial issues and concerns, provide appropriate guidance and follow-up plan, and verify that the guidance provided and follow-up plan have been implemented.

Documentation of patient care-related supervision must be maintained on file and include the following:

- Date of patient care-related supervision
- Supervision format (i.e., individual, group, case conference or multidisciplinary team case conference
- Name and title of participants
- Medical and psychosocial issues and concerns identified
- Description of guidance provided and care coordination follow-up plan
- Verification that guidance provided and follow-up plan have been implemented
- Supervisor's name, title and signature

STANDARD	MEASURE
RNs providing medical care coordination services will: • Hold a license in good standing from the California State Board of Registered Nursing • Be a graduate from an accredited nursing program with a bachelor's (BSN) or two-year nursing associate's degree • Practice within the scope defined in the California Business & Professional Code, Section 2725	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
Patient care managers providing medical care coordination services will: • Hold an MSW degree or related degree (psychology, human services, counseling) • Practice in accordance with applicable state and federal regulations, uphold the Social Work Code of Ethics (http://www.naswdc.org/pubs/code/default.asp) • Comply with the staff development and education requirements noted below	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
Case workers will hold a BA in human services; a high school diploma or GED and at least one year providing direct patient care in a related health services field.	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
Medical specialty case workers will be an LVN or certified medical assistant with at least one year of HIV experience; or an LVN license and have at least three years within a related health services field.	Resumes on file at provider agency to verify experience. Program review and monitoring to confirm.
Care managers and case workers will complete an agency orientation upon being hired and an OAPP-approved case management training within three months of being hired and other trainings as required.	Documentation of orientation and certifications in employee files.
Care managers and case workers will attend an annual one hour training/briefing on public/private benefits.	Documentation of attendance in employee files.
Care managers/case workers providing benefits specialty services will complete a countywide benefits specialty training within three months of being hired and certification in CARE/HIPP and ADAP within six months of being hired.	Documentation of training and certifications on file in employee record.

STANDARD	MEASURE
Care managers and case workers must maintain licenses by completing continuing education requirements of their respective professional boards.	Record of continuing education in employee files at provider agency.
Case managers and case workers must complete a minimum of eight hours of continuing education in HIV care-related topics per year.	Record of continuing education in employee files at provider agency.
Case workers will receive a minimum of four hours of patient care-related supervision per month from the RN care manager and social work care manager who direct the program.	All patient care-related supervision will be documented as follows (at minimum): • Date of patient-care related supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Supervisor's name, title and signature
Patient care-related supervision will provide general guidance and follow-up plans for care coordination staff and be completed as feasible and appropriate given patients.	Documentation of patient-care related supervision for individual patients will be maintained in the patient's record.

UNITS OF SERVICE

Unit of service: Units of service defined as reimbursement for medical care coordination services are based on services provided to eligible patients.

- ***Medical care coordination units***: calculated in number of patient contacts

Number of patients: Patient numbers are documented using the figures for unduplicated patients within a given contract period.

MEDICAL CARE COORDINATION-SPECIFIC PROGRAM REQUIREMENTS

TUBERCULOSIS (TB) SCREENING

All care coordination program staff, other program employees, volunteers, and consultants who have routine, direct contact with patients living with HIV must be screened for tuberculosis. Programs are directed to the TB Control Program at 2615 S. Grand Avenue in Los Angeles 90007 (Phone 213-744-6151) for more information.

STANDARD	MEASURE
All care coordination staff, volunteers and consultants with routine, direct patient contact must be screened for TB.	Record of TB screening for staff, volunteers and consultants on file at provider agency.

PATIENT/STAFF/COLLEAGUE COMMUNICATION

Agencies must develop written policies and procedures to address communication between care coordination staff, patients and other professionals to include a protocol for colleagues, social service professionals, patients, partners, family members or other

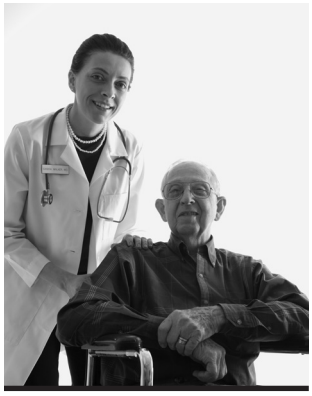
supportive persons to contact staff for emergencies, holidays and weekends.

STANDARD	MEASURE
Care coordination programs will develop policies and procedures to address communication between staff, patients, family members and other professionals, including emergency contact provisions.	Communication policies and procedures on file at provider agency.

TRANSLATION/LANGUAGE INTERPRETERS

Federal and State language access laws (Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act) require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency (LEP) patients at no cost, to ensure equal and meaningful access to health care services. Care coordination staff must develop procedures for the provision of such services, including the hiring of staff able to provide services in the native language of LEP patients.

STANDARD	MEASURE
Care coordination programs will develop policies and procedures to address the provision of competent interpretation services to LEP patients at no cost.	Interpretation policies and procedures on file at provider agency.



RN case managers coach, educate and mentor patients.

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ACRONYMS

ADAP	AIDS Drug Assistance Program
ADL	Activities of Daily Living
AIDS	Acquired Immune Deficiency Syndrome
BSN	Bachelor of Science in Nursing
CARE/HIPP	CARE Health Insurance Premium Payment Program
CRCS	Comprehensive Risk Counseling and Services
CTP	Comprehensive Treatment Plan
DHSP	Division of HIV and STD Programs
GED	General Education Development
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
LVN	Licensed Vocational Nurse
MSW	Master's Degree in Social Work
RN	Registered Nurse
SPA	Service Planning Area
SPN	Service Provider Network
STD	Sexually Transmitted Disease
TB	Tuberculosis